DOCUMENT RESUME

ED 445 462 EC 308 069

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TITLE School-Based Mental Health Services in Urban Elementary Education: Child, Family, and Teacher Perspectives.
INSTITUTION University of South Florida, Tampa. Research and Training Center for Children's Mental Health.; University of South Florida, Tampa. Louis de la Parte Florida Mental Health Inst.
SPONS AGENCY Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Mental Health Services.; National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE 1999-02-00
NOTE 4p.; In: The Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (12th, Tampa, FL, February 21-24, 1999).
CONTRACT H133B90022
AVAILABLE FROM For full text: http://www.fmhi.usf.edu/institute/pubs/bysubject.html.
PUB TYPE Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Academic Achievement; Attendance; Behavior Change; *Behavior Disorders; Consultation Programs; Elementary Education; *Emotional Disturbances; Family Programs; *Integrated Services; *Mental Health Programs; *Outcomes of Treatment; Parent Attitudes; *Program Effectiveness; Teacher Attitudes; Therapy; Urban Schools

ABSTRACT

Using urban schools to provide a pivotal platform from which to launch mental health services, the target population in this study was a group of students (n=41), ages 5-13, with serious emotional disturbances and their families at two elementary schools in Cleveland, Ohio. The children were referred for school-based mental health services by their teachers. A private, non-profit agency provided intensive mental health services, including diagnostic assessment, individual and group therapy, in-home family therapy, family support groups, comprehensive case management, intensive summer therapeutic programming, and classroom support and consultation to the teachers. Overall, 95.6 percent of the parents or caretakers were happy with the services provided though the school-based mental health program. Approximately 95.7 percent felt that their child was doing better since starting the program and they were happy with the progress that their child and family made. The children evidenced similar positive responses on their portion of the client satisfaction surveys. Results indicated that 76.4 percent of the teachers (n=18) found the consultations with the school-based mental health staff helpful, 50 percent felt their students improved attendance, 44 percent felt their students improved academically, and 39 percent felt their students' disruptive behavior improved. (CR)

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School-Based Mental Health Services in Urban Elementary Education: Child, Family, and Teacher Perspectives

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Introduction

Urban schools provide a pivotal platform from which to launch mental health services. The target population in this study is a group of SED students and their families at two elementary schools in Cleveland, Ohio (K through 6th grade). The two identified schools, one on the east side of Cleveland and one on the west side, were targeted because they had evidenced the poorest educational achievement outcomes in the district. Child, parent, and teacher perspectives on program impact were examined.

Method

The study sample consists of 47 students, of which 12.8% were female and 87.2% were male; 10.6% were Hispanic, 10.6% were Caucasian, 76.6% were African American, and 2.1% were labeled "other". The children ranged in age from 5.9 to 13.2 years with a mean age of 9.9 years. Children with the most severe emotional and behavioral difficulties were referred for school-based mental health services by their teachers. A private, non-profit agency provided intensive mental health services to these children and families including: diagnostic assessment, individual and group therapy, in-home family therapy, family support groups, comprehensive case management, intensive summer therapeutic programming, and classroom support and consultation to the teachers.

The evaluation design consisted of collecting and analyzing information across three domains: family risk factors, child academic and behavioral functioning, and consumer satisfaction. Three different perspectives were drawn upon to assess these domains: the child perspective, parent perspective, and teacher perspective.

Results and Discussion

Family risk factor data revealed that a full 90% of the referred children came from low-income families as indicated by their medicaid status. In addition, the diagnostic assessment process revealed that 59% of the children have parents with histories of substance abuse, and 42% of the parents or siblings had a history of either past or current criminal incarceration. Less than 10% of the children resided in households with both biological parents.

Of the 47 students in the sample, 25 children from the east side school had report card data available for analysis. On the average, most of the children surveyed were functioning between the D-C grade range with a

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1.7 grade point average on a 0-4 scale. The average number of days suspended for children in this subsample ($N = 25$) was 12.72 days per year.

The level of emotional and behavioral functioning of the children was measured by using the Devereux Scales of Mental Disorders (DSMD: Naglieri, LeBuffe, and Pfeiffer, 1994), a reliable and valid standardized behavioral rating instrument. Scores above 60-70 are considered to be within the elevated range of clinically impaired behavioral functioning, while 70-80 are considered to be very elevated. Both parents ($n = 44$) and teachers ($n = 45$) were asked to complete DSMD forms at the beginning and end of the school year (see Table 1).

On the DSMD total score, the mean parent rating was 62.33. For the conduct and depression subscales, the mean parent ratings were 63.51 and 62.37 respectively. Teachers rated children somewhat higher with a mean total score of 62.60, and conduct and depression ratings of 66.79 and 66.64 respectively (see Figure 1). On the DSMD total score, teachers rated 57.8% of the school sample above the clinical cut off score of 60, and 17.8% of these were in the very elevated range above 70. For the conduct subscale, 77.8% of the sample were above the cut off score of 60 and 40.0% were above 70. For the depression subscale, 75.6% of the sample were above 60 and 35.6% above 70. The majority of youngsters referred for service are within the clinical range of behavioral disturbance as measured by both their parents and teachers. A large subset of youngsters were in the very elevated range of mental health service need.

To investigate how children changed their behavior over time, a subgroup of children whose DSMD scores were available at several time points during a period of three or more quarters were analyzed. This subgroup consisted of sixteen children from the east side school who received the full array of services, including intensive therapeutic summer programming. The last DSMD observation for these children was between day 271 and day 470 ($M = 396$, $SD = 45.58$). During the observational period, both teachers and primary caretakers contributed ratings. On average, they provided 5.94 observations for each child ($SD = 1.53$) and 95 total ratings. The statistical technique used for analysis was a three-level hierachical linear model (HLM: Bryk & Raudenbush, 1992; Guo & Hussey, 1999). On the DSMD total score, the sample mean score was 65.58. Children generally changed in their total score at a decreasing rate of .0145 points per day ($p < .05$), or 5.2961 points in a one-year period. On the externalizing composite score (i.e. conduct and attention deficit), initially the sample mean score was 67.41 ($p < .01$), and children changed in their externalizing composite score at a decreasing rate of .0176 points per day ($p < .01$), or 6.42 points in a one-year period. On the internalizing composite score (i.e. depression and anxiety), initially the sample mean score was 62.27 ($p < .01$), and children changed in their internalizing composite score at a decreasing rate of .0163 points per day ($p < .01$) or 5.953 points in a one-year period. Change on the critical pathology composite score was not statistically significant. Overall, the 5 to 6.5 point decreases in DSMD scores over a one-year period is suggestive of treatment effectiveness.

Client satisfaction was measured using a standardized satisfaction rating questionnaire (Rouse, MacCabe, & Toprac, 1995) that measures satisfaction with mental health services, including provider characteristics, consumer participation, direct products of treatment, treatment outcomes, and barriers to service.

There were 41 of 47 (87%) child respondents and 23 of 47 (49%) parent/caretaker respondents. Overall, 95.6% of the parents or caretakers were

Table 1
Devereux Scales of Mental Disorders (DSMD) Scores

	Parent	Teacher
Anxiety	56.78	59.84
Depression	62.37	66.9
Conduct	63.51	66.69
Attention	59.29	57.94
Acute	60.16	56.33
Autism	60.11	58.72
Internalizing	60	63.93
Externalizing	62.15	63.02
Critical Pathology	61.13	58.02
Total	62.33	62.63

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happy with the services provided though the school-based mental health program. Approximately 95.7% felt that their child was doing better since starting the program and they were happy with the progress that their child and family made. The children evidenced similar positive responses on their portion of the client satisfaction surveys. Approximately 50% of the families identified lack of transportation as a barrier to service, specifically transportation to weekly parent support groups.

Classroom teachers who had referred children were also surveyed at the end of the academic year to help solicit feedback and evaluate the overall effectiveness of programming. Eighteen total surveys were received from the teachers. Results indicated that 76.4% of the teachers found the consultations with the school-based mental health staff helpful or very helpful to them in working with the children. Approximately 50% of teachers felt that their students improved attendance; 44% felt their students improved academic performance; 39% felt their students' disruptive behavior improved. Individual and group counseling were seen by 61% and 66.7% of teachers as the most helpful services to students, and 63.7% rated the parent support group as helpful.

Implications

Comprehensive school-based mental health programming, in conjunction with extensive family outreach, may be an effective model to improve outcomes for the highest risk youth and their families.

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Figure 1
DSMD Ratings for Entire School Sample